

Report of Public Input: Title V / Maternal and Child Health (MCH) Block Grant

**July
2013**

This report summarizes the public input received by Nebraska Department of Health and Human Services (DHHS) during the development of the FY 2014 application for the federal Title V/Maternal and Child Health Block Grant.

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Nebraska Department of Health and Human Services (DHHS)

Maternal Child Health (**MCH**) is implied to include children with special health care needs (**CSHCN**) in addition to where CSHCN are specifically referenced. MCH has many subpopulations, e.g. pregnant women, infants, children (including adolescents), children with special health care needs, women of childbearing age, and their families using a family-centered care approach.

The CSHCN Director position has long been aligned with the Medically Handicapped Children's Program (MHCP) in the DHHS Division of Medicaid & Long-Term Care. MHCP was transferred administratively to the DHHS Division of Children and Families Services effective July 1, 2013. This report identifies the CSHCN Director and Division at the time public input was received in May 2013.

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Visit the DHHS Title V/MCH Block Grant webpage to view this report online and to open the links to webpages with additional information relevant to the comments received in this public comment period. <http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/Home.aspx>

July 2013

Nebraska's FY 2014 Title V/MCH Block Grant Application: a report on public input

This report summarizes the public input received by the Nebraska Department of Health and Human Services (DHHS) during the development of the FY 2014 application of the federal Title V/Maternal and Child Health Block Grant. To further clarify and enhance the input received, this report includes additional resource information. Although the links to other webpages will not be updated, at the time of this report in July 2013 the links to webpages offer easy access when viewing this report electronically. The report features additional background information to the statewide priorities, the annual application, and the statutory purpose of public input in the development of the plan to meet the needs identified in the five-year needs assessment.

The application for the prior period (FY 2013) is available in the Title V Information System (TVIS) through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Visit <https://mchdata.hrsa.gov/TVISReports/> to review Nebraska's application, with an added feature to compare it to other states and jurisdictions. States' applications for 2014 will be available in TVIS on the HRSA webpage in mid-September for the fiscal year beginning October 1.

Title V of the Social Security Act - Maternal and Child Health (MCH) Services Block Grant

Since 1935, the federal government has pledged its support of Title V of the Social Security Act, making it the oldest, continuously funded public health legislation in U.S. History. States and jurisdictions are allocated funds based on a formula through the federal Maternal and Child Health Bureau (MCHB). Acceptance of federal Title V funds imparts responsibility to the State or jurisdiction to:

- Assure the health of all mothers and children in the state;
- Provide and promote family-centered, community-based, coordinated care (including care coordination services for children with special health care needs) and to facilitate the development of community-based systems of services for such children and their families;
- Identify specific health needs of the population through a five-year statewide needs assessment and determine health priorities;
- Submit an annual plan for meeting the needs identified by the statewide needs assessment; and report annually on performance measures;
- **Make the application public within the state to facilitate comment from any person during its development and after the application is submitted;**
- Provide a toll-free "hotline" telephone number (Nebraska's Healthy Mothers Healthy Babies Helpline is 800-862-1889);
- Comply with all rules and regulations governing federal financial assistance.

Maternal Child Health (MCH) is implied to include children with special health care needs (CSHCN) in addition to where CSHCN are specifically referenced. MCH has many subpopulations, e.g. pregnant women, infants, children (including adolescents), children with special health care needs, women of childbearing age, and their families using a family-centered care approach.

Public input

Nebraska Department of Health and Human Services (DHHS) sought public input in the preparation of its annual application of federal Title V/Maternal and Child Health (MCH) Block Grant. This report details the methods used, summary of comments received, and results of the process evaluation.

DHHS submitted its application by July 15, 2013 to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The 2014 application provides the activities and budget for the period October 1, 2013 through September 30, 2014, the fiscal year (FY) 2014.

Methods

Two methods of public input, webinars and written comments, were announced by email and on multiple websites. Computer technology has been used exclusively for several years to announce public input requests. This year DHHS utilized for the first time technology to conduct public meetings. The internet was used to host live, interactive web conferencing (or “webinar”). The technology needed to attend a webinar may not be available to all persons. Typically, however, access is available in offices of service providers, and consumers are invited to go to provider offices if this method is unavailable to them otherwise. The webinar format practically eliminates the need to travel to a geographic location, making it more cost-effective in time and expense for participants.

In April 2013, DHHS emailed an announcement to 363 addresses comprised primarily of representatives of Nebraska-based organizations interested in maternal and child health (MCH) and children with special health care needs (CSHCN). The announcement provided the webpage address to DHHS Lifespan Health, Planning & Support www.dhhs.ne.gov/TitleV_MCH, and coincided with the debut of a significant re-design of the webpage. The new webpage is Nebraska’s premier location to a variety of information about Title V/MCH Block Grant, including the *Title V Info Packet* designed to accompany the public input request. The six-page packet provides an overview of Title V/MCH Block Grant in Nebraska, and also information needed to comment on the state’s annual application.

Visitors may electronically subscribe to www.dhhs.ne.gov/TitleV_MCH, and many other webpages on the DHHS website, to receive an email notice when a page is updated. There were 748 subscribers to the Title V/MCH webpage who received a system-generated email notice when the announcement inviting input on the 2014 application was posted on the page. As a result, all 748 subscribers received notification by that method, if not by the separate email announcement sent to 363 addresses. An additional 202 visitors to the webpage have subscribed since the debut of the re-designed webpage. As a result, at least 950 persons with knowledge of the webpage and interest in subscribing were invited to and had access to the materials to provide input on the application.

Answers4Families, an ongoing project of the University of Nebraska-Lincoln's Center on Children, Families & the Law, provided the webinar technology and other technical support for the meetings facilitated by DHHS. The Answers4Families website www.answers4families.org also posted notice of the webinars. In addition, that site offered the option to provide public input online using a nine-question survey.

In its announcement, DHHS urged recipients to share the information with colleagues, consumer advisory boards, and clients. There were several indications that persons acted on that request. Subsequent invitations to provide input were made by additional webpage postings:

- Early Childhood Special Education Services - North Platte <http://ecpnppsd.wordpress.com/>
- Early Development Network <http://edn.ne.gov/>
- Nebraska Resource and Referral System <https://nrns.ne.gov/>

Baby Blossoms Collaborative (Douglas County) www.babyblossomsomaha.org distributed the email to 75 persons who may not have received it by other means.

A total of at least four additional points of outreach/promotion stemmed from the primary promotion. Several webinar participants indicated in the process evaluation either that they learned about the webinars by an email forwarded to them or that the information was shared in some way.

Consumer participation is strongly encouraged. The announcement urged service providers, as feasible, to assist consumers and families to prepare and submit their comments. Although consumer input was not received, service providers advocating on behalf of consumers is clearly evident in much of the input received.

In May 2013, DHHS staff presented an overview of Title V/Maternal and Child Health (MCH) Block in four meetings held by webinar technology. Following the brief presentation, each webinar focused discussion on different MCH/CSHCN population groups(s):

- **Pregnant Women/Women of Childbearing Age**
May 2, 2013, 9:00 a.m. – 11:00 a.m. C.D.T
- **Children with Special Health Care Needs (CSHCN)**
May 7, 2013, 1:00 p.m. – 3:00 p.m. C.D.T.
- **Infants**
May 13, 2013, 9:00 a.m. – 11:00 a.m. C.D.T
- **Children and Adolescents**
May 15, 2013, 1:00 p.m. – 3:00 p.m. C.D.T.

Several participants joined in more than one webinar.

The decision to conduct public meetings using technology was largely made to eliminate the time and expense to travel to on-site meetings, and subsequently to increase the number of participants. The trade-off minimized opportunities for preferred face-to-face interaction, although the potential gain in enhanced opportunities to comment was worthy of a trial for the

2014 application. The webinar format was selected after considering several other technology options. The basis for selection also considered the advantages of statewide interaction. A toll-free, call-in option was available to participants who preferred to provide input verbally rather than typing to use the “chat” option, or to accommodate persons without built-in computer speakers.

DHHS staff provided a brief presentation to more fully detail the information in the *Title V Info Packet*. The six-page packet was available in advance of the webinars at www.dhhs.ne.gov/TitleV_MCH. In response to participant request, the webinar presentation slides were also posted on the webpage. DHHS staff facilitated the discussion via chat and phone. Representing MCH was Paula Eurek and Rayma Delaney (DHHS Division of Public Health, Lifespan Health Services Unit). Heather Krieger represented CSHCN (DHHS Division of Medicaid and Long Term Care, State and Grant Funded Programs Unit).

At least 34 persons from a variety of organizations and communities were involved in four webinars. A few persons who participated in the webinars, either by chat and/or by phone, were not signed in, suggesting that potentially more persons were online and listening but their presence was unknown. Some webinar participants called in on the toll-free phone line, while others used chat extensively to ask questions and provide comments. Input provided in the four two-hour webinars is summarized in the next section of this report. A recording of both the audio and chat helped ensure that all information in this report is accurate and thorough.

Written input was another option for the public to comment on the annual application. Information on where and by when to submit comments was made available in the email announcement and on the DHHS webpage www.dhhs.ne.gov/TitleV_MCH, and also promoted through the four webinars. The DHHS webpage address was provided as a link from other webpages of entities who assisted with outreach/promotion. Written comments were to be received by June 7. Forty (40) representatives of two community-based groups provided input and aggregated into the two written submissions.

Altogether, 73 participants were involved in varying degrees of engagement in the public input process, ranging from listening to the presentation to exchange of information with DHHS. It is unknown how many persons may have read the information packet only. All participation is valued and appreciated.

Statewide MCH/CSHCN priorities

The annual application requires a plan to meet the needs identified in the statewide assessment which is required be conducted every five (5) years. Under Title V, the assessment shall identify the need for:

- preventive and primary care services for pregnant women, mothers, and infants
- preventive and primary care services for children; and
- services for Children with Special Health Care Needs (CSHCN)

The most recent statewide Needs Assessment was conducted during the period of spring of 2009 through July 2010. DHHS called upon a large group of persons across Nebraska representing MCH and CSHCN to provide their perspectives. This Needs Assessment addresses the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) populations in Nebraska and establishes priorities for the years 2010-2014. The assessment guides the priority-setting to invest resources such as time, expertise, and money. Not all priorities identified in the Needs Assessment can be addressed by MCH Block Grant funds. If a priority need(s) is being addressed by other resources, the Block Grant funds may be invested in priorities that do not have enough resources to address the needs sufficiently and/or where strategies can be used that impact more than one priority. It should also be noted, that while the MCH Needs Assessment is a requirement of Title V, it informs and guides planning and program development beyond that supported by the MCH Block Grant. The statewide priorities are used in this report to organize comments in the subsection 'areas of need'.

Summary of comments

Comments and suggestions received from 34 participants in four meetings and two organizations submitting written comments are synthesized and summarized in this section. All input came from representatives of organizations, many of which are providers of services to MCH/CSHCN. Family members or consumers of services were represented by the advocacy of provider organizations whose comments were on behalf of their clients. Comments are summarized by categories and organized in subsections: A. Areas of need; B. Interventions; C. Barriers & gaps; and, D. Suggested improvements.

The full report of the five-year, statewide needs assessment is available at <http://dhhs.ne.gov/publichealth/Documents/NeedsAssesmen2010FINAL.pdf>.

Throughout this section, resource information is offered as postscripts to the input received. When this report is used electronically, the links to webpages offer easy access to information that helps clarify or add to comments and suggestions. Not all valuable resource information can be known or included in this report, and what is available will be unable to be updated in this format.

A. Areas of need. *How do the state-level priorities compare to the most important health needs of mothers, infants, children, and adolescents in your local community?*

This subsection includes community insight to the statewide MCH/CSHCN priorities, and other needs in their communities. The comments are summarized by state-wide priorities, followed by additional comments that are listed by categories indirectly aligned with the statewide priorities. Comments are from all four webinars and from written input. An online survey-style option to comment was added to the Nebraska Early Development webpage after the original announcement. The page was linked from the Nebraska Resources and Referral System (NRRS) and Answers4Families websites. This method, however, did not generate input at the time of this report.

Comments by statewide MCH/CSHCN priorities (*numbered for reference*).

Statewide priority 1: **Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.**

- Kearney has an inclusive playground where children of all abilities share in physical activity.
- Of the Douglas County (Omaha metro) respondents, 50% believe this statewide priority is comparable and 50% very comparable in their area, ranking it 3rd in their local priorities.
- A written respondent representing an area of Central Nebraska notes the importance of this priority to family planning, and healthy pregnancy and birth outcomes. Adding to their comments, they cite the importance of folic acid for fetal and placental growth, and prevention of neural tube defects (NTD). NTD could result in a birth outcome contributing to a special health care need. Healthy weight also being associated with positive birth outcomes.
- An increase in the number of overweight children is observed in the Hastings area, suggesting this priority continues to be relevant.
- A big difference in school lunches in the schools in the Hastings area is noted by an observer. Some schools have a really good variety of health foods, including fresh fruits and vegetables, while others serve many processed foods and have very little variety. (Some variability is expected due to local control by Nebraska school districts. There have been special statewide initiatives by DHHS Health Promotion, although local initiatives and addressing concerns with individual boards of education could be helpful.)

Statewide priority 2: **Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.**

- Southeast region has a very high prevalence of STD's, affirming that this priority is also important for Southeast Nebraska. Commenter states that more public awareness of how STDs affect pregnancy/health is needed.
- Of the Douglas County (Omaha metro) respondents, 17% believe this statewide priority is comparable and 75% very comparable in their area, ranking it 1st in their local priorities.
- Knowledge of and access to family planning services is inadequate among young females in the Omaha area. Infants are born to moms who are not ready and continue having additional births too soon.
- A written respondent representing an area of Central Nebraska comments on the value of pre/inter-conception care and planned pregnancy. Adding, that the social and economic costs of teen pregnancy and childbearing are high; investments in family planning reduce Medicaid costs for pregnancy-related and newborn care.
- Families have so many children and so close together; more available family services are needed.

Statewide priority 3: **Reduce the impact of poverty on infants/children including food insecurity.**

- Of the Douglas County (Omaha metro) respondents 30% believe this statewide priority is comparable and 60% very comparable among infants in their area. For children in their area, 41% believe this statewide priority is comparable and 58% very comparable. This priority is ranked 2nd in their local priorities.
- A decrease in Head Start/Early Head Start due to sequestration, infants/children may be further impacted as they would have received food at center-based programs and may not have food security at home.
- Living in poverty puts you at risk for a number of health problems, and it is not just at or below the federal poverty level (FPL) but also families up to 185% FPL.
- For families in poverty, transportation is a continual barrier.

Statewide priority 4: **Reduce the health disparities gap in infant health status and outcomes.**

- Language and cultural differences effect access to care. There are some interventions in Hastings and Grand Island (Central Nebraska) to address this access barrier, but not really anything in smaller-size communities. (Evidence-based programming is not clear on whether the same effect will occur across cultures when implemented with fidelity.)
- One commenter in Central Nebraska says that the “working poor” and language/culture are the biggest disparities we see.

Statewide priority 5: **Increase access to oral health care for children and CSHCN.**

- A number of dentists do not accept Medicaid-covered patients.
- CSHCN benefit from pediatric dentists, which are limited in number. Outside of Lincoln and Omaha, there are 2 pediatric dentists in Kearney (with hospital privileges), and others in Hastings, Grand Island, and North Platte, all along the I-80 corridor. A dental clinic was recently open in Children’s Hospital (Omaha) which is helpful to coordinate dental care for CSHCN during visits for other medical procedures.
- Several commenters emphasized the value of prevention, stating that education to parents, physicians, and dentists needs to underscore the importance of starting dental exams at age 1.
- Observers in the Hastings and Kearney area state that oral health care is certainly a challenge. There is a gap in services for dental health in Central Nebraska, and not enough providers willing to see Medicaid-eligible or uninsured children.

Statewide priority 6: **Reduce the rates of abuse and neglect of infants and CSHCN.**

- (No specific comments were received, which is not thought to minimize the ongoing concern with this priority.)
- Of the Douglas County (Omaha metro) respondents, 50% believe this statewide priority is comparable and 40% very comparable in their area. This statewide priority for infants and CSHCN, however, was not in the top three priorities for that community.

Statewide priority 7: **Reduce alcohol use and binge drinking among youth.**

- Local programs to address alcohol use and binge drinking among youth had previously been funded by other federal funding until a year ago.

Statewide priority 8: **Increase quality of and access to perinatal health services, including pre/inter-conception health care, prenatal care, labor and delivery services, and postpartum care.**

- One written commenter, comprised of 36 separate respondents in Douglas County (Omaha metro), 29% believe this statewide priority is comparable and 71% very comparable to their area. Adding, it appears that access to care including good prenatal care and follow-up after delivery, is a central theme in Douglas County.
- Northeast and southeast regions have limited prenatal care and delivery options that often limit access outside of the immediate area. The numbers of obstetrics cases are low relative to the cost to provide delivery.
- Prenatal care is sometimes delayed due to \$2,000 payment expected upfront when Medicaid coverage is pending. Not all physicians accept Medicaid.
- Input from southeast and south central areas with high Hispanic populations some families did not receive prenatal care because they did not have coverage. They may have overdue bills and providers will not take them as patients, so patient needs to find another provider which leads to transportation issues.
- Having moms get as close to 40 weeks as possible is best. The March of Dimes <http://www.marchofdimes.com/nebraska/> and the Nebraska Hospital Association <http://www.nhanet.org/index.htm> have initiatives to prevent premature birth.
- We are seeing more gestational diabetes in our area in southeast Nebraska among pregnant women who lack health coverage. The local health department will do some diabetes education.

Statewide priority 9: **Increase the prevalence of infants who breastfeed exclusively through six months of age.**

- Of the Douglas County (Omaha metro) respondents 10% believe this statewide priority is comparable and 70% very comparable in their area.
- There is difficulty obtaining breast pumps through Medicaid providers in Omaha due to reimbursement. When the rental pumps are not returned, the provider is forced to take a loss on their equipment cost.
- Breastfeeding is such a cultural issue, I feel like much of the success comes by one-on-one support to moms in home visits, in conjunction with physicians who are knowledgeable and supportive which is improving but is not yet where it should be. WIC is doing good work with the Breastfeeding Peer Counselors.
- We frequently see moms start breastfeeding, but give it up when they return to work. Pumps are sometimes an issue, sometimes it is the job/hours, sometimes it is daycare. It does seem that more moms are at least trying to breast feed.

- I think it is also important that the attitudes of hospital staff towards mothers breastfeeding be supportive towards all mothers regardless of socioeconomic or marital status which I've heard others in Lincoln raise this as a concern.
- Teen moms in Omaha are not supported by hospital nurses' perception that a teen mom will not breastfeed. This is a concern to home visiting providers who have supported these teens during pregnancy and prepared them to breastfeed. We do not want gains made in the prenatal period to be thwarted in early postpartum. Schools are mixed in receptiveness to pumping at school. There are teens that want to breastfeed but cannot because of the scheduling. Omaha Public Schools has come a huge way in the last two years to support pumping.
- It helps to get school nurses on board, noting school nurses need education on current information about how to pump, store milk after pumping, and the benefits to mom and baby if they can continue breastfeeding.
- There are also high school teachers that treat teen moms differently because of their own attitudes towards teen pregnancy. Mom's education level affects the child so it is important for them to stay in school. Teen dads are not treated differently in school because they do not have the same "evidence" that they are fathers. Both are obviously involved in conception, but the male does not have the same negative attitude directed towards them as the female receives.

Statewide priority 10: **Increase access to Medical Homes for CSHCN particularly for those with functional limitations.**

- Recognize a need to improve medical providers' knowledge of referral for disability evaluation, and understanding the difference between a medical diagnosis and an educational need.
- The relationship is challenged when doctor does not listen to a teen mother or see her as an authority on her baby, delaying care to the child.
- In the Hastings area they see a number of children who do not stay with the same doctor, dentist or eye doctor. Sometimes it is because of insurance and frequent moves.
- Although not specific to CSHCN, stay updated on the Nebraska Medical Home pilot project http://dhhs.ne.gov/medicaid/Pages/med_pilot_index.aspx. See also the feature on the National Medical Home Implementation Center website http://www.medicalhomeinfo.org/state_pages/nebraska.aspx.

Input by other categories indirectly aligned to state priorities
(*numbered for reference*)

Other category 11: **Access to Medicaid and other eligibility intake**

- Multiple commenters stated that Access Nebraska, the online method to apply for public assistance benefits in Nebraska, is a significant challenge for families in need, resulting in frustration. For example, people living in need may have limited access to computer and phone, there are long waits to speak with someone in person, they may

not have enough minutes to stay on hold 60-90 minutes, and may be unable to leave message with call-back number if they are borrowing a phone. When the process is conducted in person, non-verbal cues are helpful and minimizes frustration. (Note: Effective July 1, 2013, Medicaid eligibility determination will shift from the Division of Children and Family Services (CFS) to the Division of Medicaid and Long-Term Care (MLTC). The Lincoln and Lexington customer service centers will transition to solely determine clients' eligibility for and work with Medicaid recipients and the Children's Health Insurance Program (CHIP). The Fremont and Scottsbluff will handle only economic assistance programs. Goals include reducing wait time and improving communication. The change is in response to the Affordable Care Act (ACA) requirements. Health reform may provide some gap-filling services in Nebraska when navigators begin October 1 guiding Americans through the ACA Exchanges.

<http://update.legislature.ne.gov/?p=12182>)

- Often persons in need, but unable to access Medicaid, go to local health departments. Until recently local health departments were under contract with Medicaid Managed Care Organizations to provide outreach and services information (referred to as PHONE nurses). Without the financial support, it will be challenging for local health departments to continue providing that assistance, yet persons in need will seek their assistance and the assistance of other similar organizations. Several commenters indicated the PHONE nurses through local health departments were helpful to families.
- The loss of DHHS local offices to determine eligibility through face-to-face interaction continues to be felt. Participants representing organizations with statewide presence state that consumers throughout the state have expressed having difficulty with the process. It is not unique to a region. The loss of the local office continues after several years to have a huge impact, adding that physical locations and case workers helped people feel the services were more accessible.
- One provider/commenter stated "Nebraska Access is not aptly named. They either have to use the website, which I couldn't figure out myself, and upload documents which are not specified (just "upload necessary documents"), or use the phone and wait up to 90 minutes for an answer. Both of these are difficult for low income women who have work or children and not much control over their lives."
- Multiple commenters stated that there is a lot of confusion around prenatal care coverage for undocumented pregnant women. (Note: A pregnant women who is not a U.S. citizen and low-income (no greater than 185% of federal poverty guidelines), is currently eligible for medical services related to the pregnancy. The unborn child of a mother ineligible for coverage under Title XIX of the Federal Social Security Act (Medicaid) is eligible under a separate program.)
- Commenters in two larger-sized communities said some medical providers are not completing all aspects of well child checks, e.g. lead and hemoglobin screenings or head circumference measurements, at Medicaid-reimbursed appointments. An incomplete schedule challenges Head Start programs to ensure a child's health needs are met. (Early Periodic Screening Diagnosis and Treatment (EPSDT), referred to as Health Check in Nebraska, is a comprehensive benefits package available to all Medicaid-eligible children under the age of 21. Nebraska's State Plan is available at http://dhhs.ne.gov/medicaid/Pages/med_xixstateplan.aspx. For more information, a

policy brief is available at
http://www.throughtheeyes.org/files/YB_EPSDT_Policy_Brief_2011.pdf.

Other category 12: **Early development**

- The Nebraska Chapter of American Academy of Pediatrics (AAP) is a local setting to address early brain development <http://www.aap.org/en-us/about-the-aap/chapters-and-districts/Documents/Nebraska.pdf>
- Poor parents cannot afford books for their young children and may be unable to access libraries due to limited transportation.
- Lack of quality child care affects the wellbeing of infants and families (L.B. 507, the Step Up to Quality Child Care Act, was passed by the Unicameral and signed by the Governor on June 4, 2013.
- Transportation is a problem for accessing Head Start/Early Head Start in Omaha.
- There was a question regarding whether lead screening is part of Title V. (The Block Grant is not currently investing in lead screening activities. A state law passed last year (LB 1038 in 2012 session) created a lead poisoning education and outreach program to educate health care providers, child care providers, public school personnel and parents about the risks of lead poisoning in children; provides a standard be used in identifying elevated blood-lead levels; established recommendations for testing a child who resides in zip code with high prevalence of children with elevated blood-lead levels or other criteria. Medicaid pays for testing of Medicaid-eligible children under EPSDT.)
<http://dhhs.ne.gov/publichealth/Pages/LeadIndex.aspx>
- First Five Nebraska includes among the many valuable resources, information on early brain development <http://www.firstfivenebraska.org/fullsite>.

Other category 13: **Immunizations**

- Several commenters said doctor offices give vaccinations to meet State immunization requirements http://dhhs.ne.gov/publichealth/Pages/immunization_index.aspx, but have not followed the recommended schedule by the CDC Advisory Committee for Immunization Practices (ACIP) <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Commenters added that they believe due to non-compliant clients and doctors not wanting to give multiple shots at one time, some devise their own schedules that follow neither the state requirements or CDC recommendations. They hear that doctors do not see the need for it since the state does not require it for day care licensing or school entrance.
- Teen moms' relationship with their doctor complicates staying on the vaccine schedule. One public health nurse stated that she studies the charts and the spacing is off, but believes the immunizations are probably effective. The public clinics follow the CDC recommendations.
- Vaccines for Children (VFC) is a federally-funded and state-operated vaccine supply program that provides free vaccine to eligible children. Through the combined efforts of public immunization clinics and private physicians, the program strives to increase vaccine coverage levels nationwide. Providers enrolled in Vaccines for Children (VFC) have compliance checks.

- Doctors' offices opting not to provide immunizations are due to the challenge of proper storage and handling to protect the vaccine, complicated schedules, and refer to the public clinics. The challenge is that VFC vaccines are not free of charge to insured patients.
- CDC offers "Talking with Parents about Vaccines for Infants", a helpful resource to share with health care professionals <http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/talk-infants-color-office.pdf>
- Several commenters said that NESIIS works well in the public clinics for sharing/accessing immunization records. More physicians' clinics are using NESIIS, but one of the issues for them is interfacing with their Electronic Health Records. (The Nebraska State Immunization Information System (NESIIS) maintains computerized immunization data for individuals of all ages in a confidential and secure manner http://dhhs.ne.gov/publichealth/Pages/nesiis_index.aspx. The Nebraska Immunization Program provides continual outreach and training staff of private clinics to use NESIIS. Additional activities include systems development and the Electronic Health Records transfer from physician offices.)

Other category 14: **Mental health**

- A commenter in Central Nebraska says mental/behavioral health is an area of huge need among children and adolescents.
- Limited access to mental health services generally.
- Maternal depression has an impact on the infant. It is hard to diagnosis and treat because the infant is the patient. The provider cannot bill for care to the mother.

Other category 15: **Interacting variables**

- In the metro area most problems are related to pervasive poverty in parts of Omaha. Would it be true that poverty is the biggest concern in rural areas, or more lack of access?
- Factors are intertwined. Women in poverty are often depressed, do not provide the needed stimulation to their infants, and so the early brain development does not happen, and the cycle continues. The cycle has to be broken and it is best with early childhood education.
- Domestic violence has a big impact on the children and families we see in Central Nebraska.

Other category 16: **Non-medically indicated inductions and C-sections**

- Northeast region notes that they are actively promoting full-term pregnancy. Moms do not fully understand the importance, so there opportunity for education on this topic.
- Many moms get to deliver when it works best into the doctor or mom's schedule.

Other category 17: **Car Seat Inspection**

- Huge commitment for a volunteer unless an organization is fortunate to have a trained staff person willing and able to complete a four-day class.
- It is hard to get an appointment for a car seat check even in metro Omaha.
- There are limited resources for getting car seats (and cribs) in the community. We have small amounts from a family foundation to use for our own clients, but not enough to support the entire community.
- Lincoln has a number of resources for families for car seats. Early Head Start/Head Start is also collaborating with Safe Kids on a grant it received to provide services to low-income families.

Other category 18: **Monitor trends to update needs assessment**

- Hastings area observes increase in asthma.
- Early onset of Type II diabetes in children.
- Observed increase in tobacco use among teens in the Hastings area.
- Multiple comments from persons representing Lincoln, Hastings, Kearney, and Omaha areas on the abuse of over-the-counter medications, especially cough medicine, and prescription drugs among teens. A 14 year old took an entire package of Musinex or similar medication. It dries out mucous membranes mostly, although is an indication of intent to abuse a substance. We have also heard about the random pill parties from their parent's medicine cabinets.
- A Pediatric resident in Omaha states that there are no screening mechanisms identified using blood or urine specimens. It is identified when teens come into the hospital confused and sedated mostly due to medication overdose from "Triple C" (cough, cold, congestion).
- Incidences of "cinnamon challenge" and ingestion or inhalation of other substances that may or may not be harmful were cited.

B. Interventions. *What programs and services do communities have to help address these priorities?*

This subsection offers a variety of interventions to address needs. These comments are from all four webinars and from written input. The webpage links are added to this report for additional information regarding these interventions.

- The Centers for Disease Control (CDC) resource called Tips for Talking with Parents http://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/tipstalkingparents.pdf is a helpful tool for child care providers to assist in talking with parents of children with developmental delays. Visit www.cdc.gov/actearly for a variety of resources from the CDC "learn the signs/act early" webpage.
- The Nebraska Resource and Referral System (NRRS) offers a searchable database Right Place Child Care Finder <https://nrrs.ne.gov/therightplace/> for child care statewide, including child care providers accepting CSHCN.

- Early Development Network (EDN) helps identify resources and sort out with families and other service providers who pays for what.
- Families with CSHCN who do not qualify for Medicaid or state assistance, and cannot pay out-of-pocket for services and equipment, need to know about the Shriners Hospital and clinics. There are occasions when Shriners brings a team to Nebraska for assessments of children. Shriners accepts what insurance pays and will not require additional payment from parents. <http://www.shrinershospitalsforchildren.org/> or contact any Shriner or Shrine Temple in your local area for information. Social Workers in Shriners Hospitals are a good resource for additional information.
- Sibling care, a service of the Medically Handicapped Children's Program (MHCP), provides care of a sibling while the parent transports their CSHCN to medical appointments. EDN partners with MHCP worker to coordinate services based on authorized services in the care plan.
- Some MHCP clinics continue to support social emotional issues, with transition to Boys Town craniofacial clinics. No linkage to trauma informed care.
- The Arc of Buffalo was a key partner in Kearney's All Inclusive Recreational Project which opened in January 2013.
<http://www.1011now.com/nebraskacentralnews/home/headlines/Kearneys-Inclusive-Playground-Open-for-Play-186405621.html>
- The low numbers of obstetrics cases relative to the high cost of delivery lead a Northeast provider to develop a multi-disciplinary team approach. Not only has it bumped up the numbers within a 35-50 mile radius provided prenatal care and delivery at the Providence Medical Center (PMC) in Wayne, consumer satisfaction has improved. The team approach looks at the whole patient. Starting with the referral, education and relationship building helps moms thru a healthy pregnancy and prepared for a positive birth experience and outcome. PMC "Practices 39!" to promote full-term pregnancy to reduce the odds of being born too early
<http://www.providencemedical.com/vnews/display.v/ART/519161fc2f372>.
- WIC clinic scheduling (due to its itinerant nature) cannot always coincide with births. For example, if WIC is the 1st week of the month and a newborn arrives the 2nd week, the WIC client needs formula (if mom has chosen not to breastfeed) and may be unable to travel to another WIC clinic. One local health department buys the formula, of course promoting breastfeeding first. WIC provides education and support for breastfeeding. In addition, some Nebraska's WIC sites offer Breastfeeding Peer Support.
http://dhhs.ne.gov/publichealth/Pages/wic_index.aspx
- Sarpy/Cass Department of Health & Wellness, a local health department, offers a nurse/lactation consultant who will make prenatal/postpartum home visits to help with education and breastfeeding support at no cost to the family
http://www.sarpycasshealthdepartment.org/nursing_outreach.html.
- MilkWorks, a Lincoln-based, non-profit organization, should be a model of comprehensive breastfeeding services for other clinics throughout the state.
<http://www.milkworks.org/>
- DHHS Office of Women's Health promotes the benefits of breastfeeding
<http://dhhs.ne.gov/publichealth/Documents/Breastfeeding.pdf>
- La Leche League is international, with local support in areas of Nebraska
<http://www.lalecheleague.org/nb.html>.

- DHHS should sponsor classes for persons to become certified lactation consultants and offer it at a reasonable registration fee.
- Healthy Pathways at Public Health Solutions, a local health department in southeast Nebraska, utilizes a partnership of Community Health Workers (CHW) and public health nurses to help ensure that consumers in their district are accessing care in the most appropriate place and improve patient outcomes. This is also an opportunity to catch up childhood immunizations.
- The Young Children Priority One (YCPO), a dental program offered by Two Rivers Public Health Department, a local health department in Central Nebraska, helps gap-filling in Central Nebraska. YCPO is recognized by the National Association of County and City Healthy Officials (NACCHO) as a Model Practices Program for demonstrating exemplary and replicable qualities in response to a local public health need.
- Two Rivers Public Health Department and Community Action of Mid Nebraska partner in its programming, e.g. YCPO, WIC, and Immunization clinics, utilizing Community Health Workers who assist families with cultural and language barriers that otherwise would limit families' health literacy to fully benefit from available resources. CHWs also offer families information and referral to other community resources.
- The Educare curriculum puts family involvement is at the center of its development strategy for improving school readiness for at-risk kids.
http://www.educationnation.com/casestudies/earlyed/NBCCaseStudy_EarlyEd.pdf
 Educare centers have popped up nationwide. In Nebraska, Educare of Omaha <http://www.educareomaha.com/about.asp>, Educare of Lincoln <http://wp.lps.org/educarelincoln/>, and the first Educare center on an American Indian reservation is Educare Winnebago (Winnebago Tribe of Nebraska) <http://www.winnebagotribe.com/images/WINNEBAGO%20NEWS/WIN%2003-02-13/WIN%2003-02-13s.pdf>.
- Local programs to address alcohol use and binge drinking among youth had previously been funded by other federal funding until a year ago. Eastern Central District Health, a local health department working with community partners, conducts youth substance abuse prevention activities in two counties, including Responsible Beverage Server Training, sobriety checkpoints, mass media campaigns, school-based programs and compliance checks. (This is one example of Title V Block Grant funds currently at work in local communities.)
- Head Start/Early Head Start works really hard to address physical activity, healthy eating, and access to oral health care in the Hastings area, and can always use more work.
- Lincoln-Lancaster County Health Department with its community partners helps to integrate the 54321GO! message to inform families of minimum amounts to eat/drink/do to live a healthy lifestyle: 5 fruits/vegetables, 4 servings of water, 3 servings of low-fat dairy, 2 hours or less of screen time, 1 hour or more of physical activity. 54321GO! is developed by developed by The Consortium to Lower Obesity in Chicago Children. Messaging is incorporated in a variety of programs within organizations and businesses to prevent childhood obesity <http://www.healthylincoln.org/getfit/home/54321go.html>. These efforts have been spotlighted in recent media nationally

<http://www.healthycommunitieshealthyfuture.org/spotlight-on-lincoln-nebraska/> and within Nebraska <http://www.1011now.com/news/headlines/Mayor-Beutler-Announces-Two-Efforts-to-Fight-Obesity-200486201.html>. (This is one example of Title V Block Grant funds currently at work in local communities.)

- Teach a Kid to Fish (TKTF) <http://www.teachakidtofish.org/> is a non-profit organization to prevent and reduce the incidence of childhood obesity by empowering Lincoln children and families to eat healthy and be active. works to get physicians to screen for symptoms of diabetes and chart BMI every visit. TKTF led by pediatrician Karla Lester, M.D. has found that physicians are uncomfortable charting BMI and discussing it with families. To help overcome that barrier, TKTF is providing doctors with tools such as motivational interviewing to help ease them into discussion with patients.

C. Barrier and gaps. *What barriers or gaps could be overcome through better coordination?*

This is a summary of comments regarding barriers or gaps. Resource information is added as relevant to the comments from the four webinars and written input.

- Lifespan Health Services should provide an online clearinghouse for relevant information either by link to other resources, or brief clarification of policies. For example, to avoid confusion about Medicaid eligibility of pregnant woman and the unborn child, a clear statement would eliminate the confusion for medical coverage of prenatal care: *"In April 2012 the Nebraska Legislature overrode a veto to pass L.B. 599. The bill establishes medical coverage, including prenatal and labor/delivery, through a separate program solely for the unborn child(ren) of mothers ineligible for Medicaid due to non-citizenship status."*
- Even working in EDN for years, MHCP specialty clinics are hard to understand. It seems that some of the clinics have changed, so it would help to have reminders and notice of schedule changes posted.
- Develop a notification system to human service agencies when major policy changes are made so they could communicate it to families.
- Overpayments of Supplemental Security Income (SSI) can affect a family's eligibility for the Disabled Children's Program (DCP). Families become frustrated when expense receipts are rejected that they may feel the program is not worth the hassle. (Note: Overpayment status is addressed in regulations, allowing eligibility to remain open for up to a six-month period.
- More outreach is needed, using multiple methods, to medical providers keeping them informed of available resources, engaged with referral organizations, and educated on relevant topics. Health/human service providers can support individuals/parents on methods to talk with medical providers.
- The Nebraska Breastfeeding Coalition <http://nebreastfeeding.org/> is addressing coverage and the availability of breast pumps as rental equipment through Medicaid.
- Towards reducing the rates of child abuse and neglect, improve coordination of the variety of home visiting programs to help ensure that services are best distributed among the population with this need. (The Nebraska Home Visiting Partnership helps centralize information, e.g. The Nebraska Home Visiting Core Principles and Practices, in

seven online training modules.

<http://www.answers4families.org/other/common/homevisiting/>.) DHHS Lifespan Health Services administers federal and state-funded contracts and grant awards to local communities for evidence-based home visiting

http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_home_visitation_home-visiting-needs-assessment.aspx.)

- The DHHS School Health Program manager role is invaluable in the coordination of school nurses and health information statewide. (This is a state-level Title V/MCH Block Grant investment. Examples of the School Health Nurse Coordinator role: in response to an emerging concern among school-age children's abuse of over-the-counter medications, she is providing technical assistance to school nurses statewide, and also participates in the Injury Prevention stakeholder group to identify with other health professionals what activities / programming is needed.)
- For persons In need of food pantries, counseling, utility assistance, or other human services, the easiest way is to simply dial 2-1-1 to talk to an information and referral specialist who has the community's most extensive human service database at their fingertips. If you prefer to search online using the 211 database, visit <http://65.166.193.134/IFTWSQL4/uwml/public.aspx>. Visit Nebraska 2-1-1 <http://www.uwmidlands.org/211> for more information.
- Similarly, the Nebraska Resource and Referral System <https://nrrs.ne.gov/>, a statewide database was created with input from Nebraska families, service providers and organizations. NRRS provides toll-free phone numbers, websites and email contacts to connect faster to the services you are seeking. This database provides a diverse selection of service providers and allows users to locate and compare services of local and state agencies.
- One commenter stated that they have found younger parents prefer to receive information via text, Facebook, Twitter, etc. (Title V requires that states provide a toll-free "hotline" telephone number (Nebraska Healthy Mothers Healthy Babies Helpline (HMHB) - 800-862-1889) Usage has declined over the years, likely the result of technology changes, i.e. cell phone plans with limited minutes, use of mobile apps, Twitter, Facebook, etc. DHHS is interested in suggestions about new methods to promote and/or augment usage of HMHB to be able to utilize other technology options.
- Another commenter agreed that social media is a great method to communicate fast and efficient, IF you have the budget for dedicated staffing to keep a commitment to post daily/weekly and respond to inquiries in a timely manner.

D. Suggested improvements. *What would improve the health of MCH/CSHCN?*

This is a summary of suggested improvements. Comments are from all four webinars and from written input.

- Douglas County has many effective programs and services. Improved coordination would further enhance infrastructure. Areas for improvement include focus on early childhood, access to mental health services, and place greater emphasis on father involvement.

- Improve communication and coordination of resources across DHHS to overcoming gaps and barriers.
- Child care providers often do not accept children with special health care needs (CSHCN) into their care. More information and supports are needed to improve knowledge of health conditions that leads to greater comfort and willingness to accept CSHCN into their care.
- Utilize effective communication tools and supportive media, e.g. social media and a central clearinghouse website for all things MCH/CSHCN. Develop a communication plan to send out periodic updates within EDN about MHCP clinic schedules, staffing changes, and resource information. (After the webinar, the Early Development Network distributed an overview of MHCP and will invite MHCP to make a presentation at the EDN Annual Conference in June regarding services provided.)
- Develop an electronic method to timely notify the public when there are changes to Medicaid, SNAP, WIC, and other programs.
- Develop a social marketing campaign to prevent disability, e.g. never shake a baby which could lead to shaken baby syndrome.
- Title V, together with Medicaid partners, identify strategies to address barriers and access to services, with particular emphasis on improved customer service. One commenter said the top priority should be fixing the call center for Medicaid (Access Nebraska).
- Enforcement for full compliance with EPSDT, i.e. those providers reimbursed for EPSDT well child visits are completing all aspects of the exams. (Note: DHHS Medicaid staff said managed care being implemented statewide through Managed Care Organizations (MCOs) in the preceding year is a contributing factor. The screenings may be billed by an office visit or by individual procedures covered through EPSDT. Education is warranted; provider education on billing codes; consumer education for the different types of screenings for children at certain stages/ages and under various circumstances. See “Recommendations for Preventive Pediatric Health Care” by Bright Futures and the American Academy of Pediatrics. This resource is available <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.)
- Longer qualification periods for Medicaid because families go on/off coverage, and support doctors to follow EPSDT requirements.
- Increase access to mental health services for uninsured women with maternal depression.
- A health care system issue is when the physician identifying maternal depression is not the provider. Screening and treating for maternal depression is relevant to the child, just like lead or secondhand smoke. If mom isn’t mentally well, then baby probably isn’t either. If primary care physicians and pediatricians could be reimbursed for screening mom for depression as part of the infant/child assessment, we might have better chances for improvement.
- Develop a brain development awareness campaign for the public, and sometimes providers need it, too, although leadership varies community-by-community and how to best accomplish it.

- Multiple commenters would like to see more Community Health Centers (or federally qualified health centers (FQHCs)). Fluoridated water systems, available car seat checks, Early Head Start slots, and mental health care, and a wish that VFC was easier to manage and access were on others' wish list.
- Fluoride application programs have been beneficial in preventative dental care, especially in the communities without fluoridated water. We appreciate the programs we have in place.
- Compile statewide lists of providers, especially dentists, willing to see Medicaid-eligible or insured kids. (DHHS Office of Oral Health and Dentistry is not presently staffed. Information will be shared with future staff and with Medicaid.)
- Continue adding more work sites that have workplace policies to support breastfeeding moms, e.g. reasonable break time to express breast milk, breastfeeding rooms, recognition through awards, etc. (The federal Affordable Care Act has provision that employers with 50 or more employees provide breastfeeding support in the workplace. <http://www.usbreastfeeding.org/Workplace/WorkplaceSupport/WorkplaceSupportinHealthCareReform/tabid/175/Default.aspx>)
- Promote and educate parents on the importance of reading and talking to their children at a young age.
- Many of these ideas/suggestions are things that in the long run would actually save taxpayer dollars, it is a matter of getting everyone to understand the importance of funding preventative services. These are long-term investments.
- Lincoln has a good safety net and network of services for children and families' health needs. Our focus on barriers and gaps today should not negate the positive things happening.
- Before attitudes and habits form, as part of their medical training to become physicians, physician assistants, and nurses, educate students on issues (especially families in poverty) and topics that are important in early childhood. When they get into the field they would be better equipped to educate parents.
- DHHS School Health Program could offer education to school health nurses statewide on how to support breastfeeding teen moms. <http://dhhs.ne.gov/publichealth/Pages/schoolhealth.aspx>.
- One commenter recalled the great tobacco campaigns growing up, but the generation now seems to not have the media exposure we had in the 1990s. Lincoln has just designated city parks 'tobacco-free'. (Public health practice has evolved over time, using fewer public awareness campaigns and now leading more policy-level changes to positively impact the public's health. Title V partners with colleagues in Tobacco Free Nebraska <http://dhhs.ne.gov/publichealth/Pages/tfn.aspx>.)
- Increase utilization of Community Health Workers (CHW). CHWs are an asset to empower families, and when they are of the same culture or especially culturally-sensitive to the population they work with, all the better.

Evaluation of webinar process

Participants were used to complete a process evaluation using an online survey following each webinar. Responses were summarized by webinar, as available.

Webinar 1: Pregnant Women/Women of Childbearing Age (n = 18; 28% response rate)

There were 18 participants in the first webinar, with five evaluating. All respondents heard about the meeting by email notification directly sent to them or an email or other notice forwarded to them by a colleague. All five respondents indicated the webinar method was acceptable to them, with additional positive comments from two persons about the meeting structure. Fortunately the comment “I had difficult hearing at times” was also expressed during the webinar so that appropriate corrections could be made to improve the ability to hear the audio for the remainder of this webinar. A different microphone was used for the remaining sessions. The timing of the meeting was rated good by all five respondents. All indicated there was enough time allotted for the meeting, the content was appropriate for their interest and needs, and that they were satisfied with the opportunities to participate.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

- I’m hoping for some changes in approaches to notifying human services of changes to Medicaid, SNAP, WIC, etc.
- Appreciate having input on the new application.
- I hope the input will be used to confirm the priorities and enhance activities around those priorities. Mental health is certainly a huge issue and one that seems to lack resources in the rural areas.

“Please provide feedback on the structure of the meeting . . . ”

- I liked the chat feature to type comments/questions.
- It worked well.
- I had difficulty hearing at times.

“Please provide your recommendations for soliciting public input in the future . . . ”

- I was unclear on what the webinar today would be. Perhaps a clearer description of the purpose of the webinar or giving questions out in advance would allow more time to consider responses to share during the webinar.

Webinar 2: Children with Special Health Care Needs (n = 5; 60% response rate)

Five persons participated in the second webinar, with three evaluating. One respondent heard about the meeting via Facebook and also an email forwarded to them by a colleague. Two persons indicated they learned of it from their director; the method the directors learned of it is unknown. All three respondents indicated the webinar method was acceptable to them. One additional positive comment about the structure was the person who said they liked the “talk

show” concept. The timing of the meeting was rated good by two respondents and average by one person. All indicated there was enough time allotted for the meeting, one person adding that they would have liked less time to express their views. All respondents indicated that the content was appropriate for their interest and needs, and that they were satisfied with the opportunities to participate.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

- Improved communication and connections through state programs and related services by other organizations, e.g. Shriners.
- When I can advocate for improvements on behalf of infants and families, I need to shoot for the moon – so some ideas are idealistic, but maybe the state can meet communities in the middle.

“Please provide feedback on the structure of the meeting . . . ”

- I liked the “talk show” concept.
- There were opportunities to share information about resources.

“Please provide your recommendations for soliciting public input in the future . . . ”

No recommendations were shared in this evaluation.

Webinar 3: Infants (n = 6; 0% response rate)

No evaluations were received.

Webinar 4: Children and Adolescents (n = 4; 0% response rate)

No evaluations were received.

Conclusion

Public input webinars were generally conducive for a good exchange of information between facilitators and participants. The audio option, by its nature, provided for more simultaneous, interactive dialogue than did the chat feature which created delayed responses, particularly when multiple participants were chatting and another person was speaking. It was slightly more challenging to respond to input from both audio and chat options than if a single option to either type or speak had been employed. It is believed that there was an increased understanding by all parties despite limited interaction between participants using this method. The minimal commitment of time by facilitators and participants is an important factor in this method compared to the travel time that would be added had on-site meetings been the method used. To our knowledge, no participants incurred costs to participate in a webinar, other than their time. It is acknowledged that participants’ contribution of time and knowledge are valuable contributions to this process.

Two written submission were received, each representing multiple persons who contributed to consolidated input. One written submitter solely used this method. The other submitter represented persons that may have also been webinar participants. Written input allows flexibility to prepare and submit comments when it is most convenient. On a less positive note, this method does not lend itself to interaction with DHHS staff or with other commenters. One written submitter had first surveyed stakeholders, soliciting their responses to an online survey. The results were used to prepare a report representative of the collaborative group.

In the present comment period the number of webinar participants (n=34) exceeded the number of written submissions (n=2). An estimated four persons contributed their individual input into the one written submission. The other submitter indicated 36 persons responded to their collaborative survey using Survey Monkey. The actual numbers of persons involved in the two written submissions (n=40) compared to the number of persons who participated in webinars (n=34), could suggest that written submission was the preferred method over webinar participation. Persons submitting written comments were not offered an opportunity to evaluate that method, combined with a low response rate of webinar participants, does not adequately allow for a comparison between the two methods. Despite a low response rate, the overall tone of the webinar evaluations was favorable.

Future requests for public input on the Title V / MCH Block Grant will consider these results. The DHHS team responsible for the Annual Application appreciates the opportunity to receive public input in the development of the FY 2014 application. Thank you to those who submitted comments in writing and participated in webinars.